

Health Insurance Waiver Form

Please circl	le your unio	า:					
AFSCME	BUILDING	TRADE	CODE	FIRE	NON-REPRESENTED	POLICE	
Name			Employee ID#				
SS#			Department/Division				
Present cov	verage:	[] In	othem [] Singlo [] Famil tegrated I not pres	y HRA	e insurance with the city		
I would like	e to waive:	[] Health Insurance [] Dental Insurance* [] Vision Insurance* Effective Date:					
	waiving cov ently have i	nsurance [] Sp [] Ar	oouse/Equ nother City ty of Cinci	y employ			
Insu	rance Carrie						
ID#	÷		EP/Spouse's SS#				
I hereby w	aive the ins	urance co	overage, a	s indicate	ed above, through the Cit	y of Cincinnati.	
					e able to re-enroll until the nt and lose my insurance		
Signature _			Date				
*FOP and A	AFSCME unio	n employ	ees need	to contac	t their union regarding der	ntal and vision benefits.	
*Managem	ent employe	es' denta	al and visi	ion benef	its are 100% employer pa	ıid.	

Risk Use Only: Effective Date of Waiver

Form IN Revised 09/2016